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The Benefits Improvement and Protection Act (BIPA) and its impact on the stability of provider networks in medicare + choice managed care organizations (MCOs)

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THE BENEFITS IMPROVEMENT AND PROTECTION ACT (BIPA)
AND ITS IMPACT ON THE STABILITY OF PROVIDER NETWORKS
IN MEDICARE + CHOICE MANAGED CARE ORGANIZATIONS (MCOs)

by
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A professional paper submitted in partial fulfillment
of the requirements for the

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CHAPTER 1

INTRODUCTION

Medicare beneficiaries may elect to receive their health care benefits through either the Original Medicare Plan or through a health plan offered by one of the many private companies that contract with the Medicare program to offer Medicare health plans. These private companies, called Medicare + Choice (“Medicare plus Choice”) plans, include private fee-for-service insurance companies and managed care organizations (MCOs). The fee-for-service Medicare+Choice plans usually offer beneficiaries somewhat lower costs than the Original Medicare plan with a fairly wide selection of doctors who are willing to accept the plans’ payments. The managed care Medicare+Choice plans offer beneficiaries substantially lower costs, but with a narrower selection of providers who belong to the MCO, and usually provide additional benefits over and above those offered under traditional Medicare (such as prescription coverage). Depending upon where a Medicare beneficiary lives, he or she may have more than one Medicare+Choice plan from which to choose.

Under the Medicare+Choice managed care program, the federal government continues to collect the monthly Medicare premium from the beneficiary and in turn pays the MCO a fixed rate for that individual’s health care, regardless of the actual cost. Initially, this rate was equal to 95% of what Medicare projected it would cost to provide health care services each month to a Medicare beneficiary under traditional fee-for-service Medicare. The rate was county-specific and varied throughout the country. With the passage of the Balanced Budget Act (BBA) in 1997, the beneficiary’s demographic characteristics and an indicator of his or her health status were incorporated into the calculation for the monthly payment (GAO, November 2001). The BBA also imposed a 2 percent annual rate increase limit.

From 1991 to 1998, the number of MCOs contracted with the Medicare program rose from 93 to 346, increasing the percent of the Medicare population with access to at least one Medicare+Choice managed care plan from 49% in 1993 to 72% in 1998. Beginning in 1999, MCOs across the country elected to withdraw from what used to be a profitable market segment for them, citing regulatory burdens and the government's 2 percent annual rate increase limit. Faced with provider demands for higher payment rates and resistance to capitated contracts, in which the physician agrees to provide healthcare services for a fixed amount of money per enrolled individual, MCOs declared they could no longer control their medical costs. By May 2002, the number of contracted MCOs was reduced by more than half to 152, thus dropping the percent of beneficiaries with access to at least one Medicare+Choice managed care plan to 62% (Centers for Medicare & Medicaid Services, 2001, Tables 75 and 76).

In response to the Medicare beneficiaries' dwindling pool of alternative choices to traditional Medicare, Congress passed the Benefits Improvement and Protection Act (BIPA) of 2000. BIPA was designed to generate more geographical equity in payment and, for 2001, raise the annual rate increase limit from 2 percent to 3 percent (Gold and Achman, 2001). Hoping to reverse the exodus of MCOs by providing them with additional dollars, Congress allowed MCOs to use the additional money in any combination of four options, one of which was the enhancement of beneficiary access to health care providers. The vast majority of the MCOs elected to pass the additional dollars through to their provider network in an effort to enhance or stabilize them. Of the 5.6 million Medicare MCO enrollees, 65 percent were in MCOs that used the funds for this purpose only. Of the 17 percent who were in MCOs that used the additional dollars in a combination of ways, 86% of them were in plans that chose to use a portion of the money on their provider network (HCFA Press Office, 2001).

MCOs report annually to the Centers for Medicare & Medicaid Services (“CMS,” formerly known as the Health Care Finance Administration, or “HCFA”) on the stability of their provider networks. By June of each year, MCOs participating in the Medicaid program tell CMS what percentage of their physician network has left since the end of the previous year (annual turnover rate). In reviewing the existing literature on the BIPA policy, there appears to be limited study on the relationships among the BIPA dollars, the MCOs’ abilities to provide Medicare beneficiaries with enhanced access to health care providers, and the MCOs’ continued participation in the Medicare + Choice Program. Therefore, this professional paper seeks to assess whether the additional BIPA funds provided to the MCOs stemmed their exodus from the Medicare program by enabling them to stabilize their provider networks. Using a quasi-experimental design, this paper will explore the relationship between the additional BIPA funds and provider turnover rate and, subsequently, between the provider network stability and an MCO’s decision whether or not to continue to participate in the Medicare program.

CHAPTER 2

REVIEW OF LITERATURE

The TEFRA HMO Program

Managed care officially entered the Medicare program in 1985 when the Medicare Risk HMO program was initiated under the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA established a prepayment mechanism by which the federal government would pay MCOs a monthly rate. This rate was equal to 95% of what Medicare projected it would cost to provide health care services each month to each Medicare beneficiary under a fee-for-service arrangement. This county-specific cost, referred to as the adjusted average per capita cost (AAPCC), varied throughout the country. In return for this defined prepayment, the MCO was required to provide all Medicare benefits and, at its discretion, include additional services not covered under Medicare, such as prescription drugs (Brown, Bergeron, Clement, Hill, and Retchin, 1993).

The intent of the TEFRA legislation was to “give Medicare beneficiaries the option to enroll in an MCO as a cost efficient alternative to fee-for-service health care” (Congressional Research Service, 1997). Under this capitated arrangement, the federal government was able to pass the “risk” of health care costs on to MCOs and thus control a predetermined budget for the segment of the Medicare population who elected to join MCOs. In turn, the MCOs were subsequently profitable by controlling their medical costs through various reimbursement and risk sharing arrangements. These arrangements typically include: salaries for physicians employed in MCO-owned medical facilities; modified fee-for-service arrangements in which providers are paid according to a schedule, but also receive financial incentives to control costs; and, the more extreme form of risk-sharing, capitation, in which the MCO pre-pays providers a

specified amount per patient to deliver a specific package of services over a period of time (Tufts Managed Care Institute). As with the federal government's AAPCC, the MCO's capitation rates were based on projections of utilization of services and costs.

From 1987 to the early 1990s, the number of Medicare MCO plans declined as existing contracts terminated; however, between 1993 and 1996, the total number of participating plans more than doubled (Congressional Research Service, 1997). Beneficiary enrollment in Medicare MCOs also rose rapidly between 1993 and 1999, from 1.8 million to 6.3 million, reflecting 16% of the total Medicare population (Henry J. Kaiser Family Foundation, 2001).

Although the TEFRA HMO Program offered choice to Medicare beneficiaries and enrollment in MCOs was on the rise, it was a limited choice. The beneficiaries' only options were to stay with the traditional fee-for-service Medicare program or receive care with an HMO environment.

The Medicare+Choice Program

Provisions of the Balanced Budget Act of 1997

According to the CMS, the Balanced Budget Act of 1997 (BBA) "included the most extensive legislative changes for Medicare since the program was enacted" (CMS "Medicare's Milestones" web site: <http://www.cms.hhs.gov/about/history/mcaremil.asp>). In an effort to expand choice, the Medicare+Choice Program was created to give Medicare beneficiaries the option to receive their healthcare benefits through the traditional Medicare fee-for-service program or through one of the following Medicare+ Choice plans:

1. Coordinated care plans, which include
 - Health maintenance organizations (HMOs)
 - Provider-Sponsored Organizations (PSOs)
 - Preferred Providers Organizations (PPOs),
 - Religious fraternal benefits plans
 - Other coordinated care plans that meet the Medicare+Choice standards;

2. Medical Savings Account (MSA)/High Deductible Plans;
3. Private fee-for-service plans (PFFS).

Despite Congress' best efforts to create more choice for Medicare beneficiaries, with the exception of one PSO and one PFFS plan, HMOs remained the primary alternative to traditional Medicare (Henry J. Kaiser Family Foundation, 2001).

The purpose of the BBA was to cut federal spending. A critical component in the budget agreement was the spending reductions for the Medicare program (Moon, Gage, and Evans, 1997). As Moon, Gage, and Evans point out in their summary of the BBA, without the targeted \$116.4 billion net spending reductions, a balanced budget would not have been achieved. The largest share of savings was scheduled to come over a ten-year period from the reduction in private plan payments; the BBA mandated a ceiling of 2 percent on all annual payment increases to the MCOs.

The BBA revised the payment rate the government would pay to MCOs per enrollee per month. The payment was based on the rate in the county in which an enrolled beneficiary lived.

The county payment rate was the greatest of:

1. A minimum 2 percent increase over the prior year's rate
2. A minimum dollar amount called a "floor." (This was \$402 in 2000.)
3. An amount derived from blending the local rate with a national rate based on historic spending under the "fee-for-service" Medicare program (HCFA Press Office, 2001).

Decline in MCO Participation in Medicare+Choice Program

Starting in 1999, two years after passage of the BBA, MCOs begin reducing benefits, reducing service areas, and in some cases, completely exiting the Medicare program. From 1999 to 2001, a total of 151 contracts were terminated and 165 service area reductions became effective, impacting almost 1.7 million beneficiaries (Stuber, Dallek, and Biles, 2001). A

number of studies were initiated to determine the driving factors in the MCOs' decisions to no longer participate in the Medicare program.

A study by Achman and Gold (2002) from Mathematica Policy Research used secondary data collected from the CMS Medicare Compare database (a consumer-oriented summary of plan information) and the CMS State/County/Plan Quarterly Market Penetration File (a database containing enrollment information in each county by contract). The merged file that was created from these two sources included information on contracts, service areas, county enrollments, and benefits. Achman and Gold compared the MCOs that had announced their intention to withdraw from the program in 2001 with those MCOs that had elected to remain, controlling for the degree of urbanization and the payment rate for the area from which the MCO withdrew. They found that the MCOs that withdrew suffered from a number of competitive disadvantages.

The first disadvantage was lower enrollment totals. In 2000, the average enrollment for all Medicare MCOs was 23,411. For those MCOs that elected to renew at least part of their contract for the next year, average enrollment was 26,357, as compared to 8,057 for those MCOs that elected to withdraw completely, a significant difference. This difference held true whether the withdrawal was from a rural county or a metropolitan one. The researchers for this study note that their results were similar to those of a General Accounting Office (GAO) analysis in which Medicare MCOs that withdrew from the program tended to do so from areas where they had attracted low enrollment or had just recently entered the market. Larger enrollment numbers can translate into leverage for MCOs when negotiating contracts with providers.

Two other disadvantages cited by the study were related to benefits. Achman and Gold (2002) determined that those MCOs that withdrew from the program offered less generous benefit packages and the benefit packages they did offer were less stable from 1999 to 2000.

The competitive disadvantage of a less generous benefits package is particularly true for prescription drugs, an especially attractive benefit to Medicare enrollees. Achman and Gold (2002) found that approximately 80 percent of enrollees in MCOs that renewed their contract for 2001 had some drug coverage in 2000, compared to 69 percent of enrollees in MCOs that withdrew. Upon further analysis, the researchers found that this difference was most significant in counties that received low AAPCC payment rates. Of the MCOs that offered prescription drug coverage, those MCOs that exited the program had also set lower annual dollar limits on the benefit or were less likely to offer an unlimited benefit, as compared to those MCOs that renewed their contract. Again, Achman and Gold note that their findings support similar findings in the previous GAO study.

The stability of the benefit package was measured by premium changes and changes in prescription drug coverage. Of the MCOs that withdrew, 42 percent had reduced their drug coverage from 1999 to 2000 by either dropping the benefit entirely or by lowering the annual limit on the benefit. This is compared to 23 percent of those MCOs that renewed their Medicare contract.

Another study conducted by Stuber, Dallek, and Biles (2001) for the Center for Health Services Research and Policy at The George Washington University Medical Center examined reasons for withdrawal in seven Medicare+Choice markets: Cleveland, Houston, Los Angeles, Minneapolis-St. Paul, New York, Tampa-St. Petersburg, and Tucson. With the exception of Minneapolis-St. Paul, these markets had experienced steady growth in MCO enrollment throughout most of the 1990s, some as strong as 500 percent increases in market penetration rates. Using data collected during site visits to the seven markets (including interviews with MCO executives, providers, and members of the senior community) the researchers determined

that both national and local factors contributed to various MCOs' decisions to withdraw from these markets in 1998, 1999, and 2000.

One of the national factors identified by the study was the AACPP payment rate. MCO executives reported that the BBA's annual 2 percent limit for rate increases on already low base payment rates did not offset their general medical cost inflation rates of 7 to 10 percent per year and their prescription drug cost increases of 12 to 20 percent per year.

The Stuber, Dallek, and Biles study identified five local factors as contributors to MCO withdrawals: provider pushback; increasing use and costs of care; national MCOs leaving local markets for more lucrative employer-based enrollment; fear of adverse selection; and low market share. The authors describe provider pushback as "a growing unwillingness of providers to accept plan payment levels." Where once capitation was believed to be the tool of the future for controlling medical costs, it has now "lost ground where it was popular and failed to catch on elsewhere" (Tufts Managed Care Institute, 2002). The provider pushback described by Stuber, Dallek, and Biles in their study, appears to support this theory. MCO officials reported that in all seven cities providers were migrating away from risk-sharing arrangement, including capitation, and demanding fee-for-service reimbursement. One official described risk sharing as "almost a dinosaur" and stated that "the days of providers accepting the risk for patient care are numbered." Provider resistances to accepting payments, and in some cases refusing to contract with Medicare MCOs altogether, were cited in all seven markets, as reported by MCO executives and community sources. Stuber, Dallek, and Bile speculate that the strength of the providers in these cities to "define the terms of plan payment arrangements" was the result of practitioners consolidating into large organizations. Although not addressed by this study, this theory may apply to other areas of the country, especially in markets where large numbers of individual

providers contract with Individual Practice Associations (IPAs), which in turn negotiate contracts with MCOs for them.

Additional analysis of the data that were collected during the seven-market study was conducted by Stuber, Dalle, Edwards, Maloy, and Biles and released in their 2002 follow-up report, Instability and Inequity in Medicare+Choice: The Impact on Medicare Beneficiaries. In addition to the MCO-provider disputes that were cited in their first study, this study identified provider financial problems as a source of disruptions in the provider network for many MCOs. According to the sources interviewed for the study, capitation arrangements by MCOs that pass the financial risk of care down stream to contracting providers served as a source of financial hardship for physicians.

This finding was supported by another study conducted by Dallek and Dennington (2002) in which they analyzed physician withdrawals from Medicare+Choice MCOs as a source of program instability. The researchers used primary care provider turnover rates in 38 states and the District of Columbia, metropolitan-specific primary care provider turnover rates in the seven Stuber, Dallek, and Biles study markets, and primary care, cardiology, and hospital turnover rates for the cities of Cleveland and St. Petersburg. For the 38 states and the District of Columbia, the 1999 data came from the CMS Medicare Health Plan Compare database. According to the report, provider turnover rates varied widely, from 4 percent to 36 percent, with 14 percent as the national average.

There were similar findings when reviewing turnover rates for the metropolitan areas. Again, using data from the CMS Compare database, Dallek and Dennington found turnover rates ranging from a low of 1 percent to a high of 31 percent. Not only were there wide variations across markets but within individual markets as well.

To examine turnover rates more closely, the researchers analyzed MCO provider directories from the cities of Cleveland and St Petersburg, determining whether providers listed in the 1999 directories were also listed in the 2001 directories. Dallek and Dennington acknowledged that the directories used are only a snapshot in time and may not be reflective of the dramatic movement that can happen within a provider network (e.g., one official reported his MCO was about to release its fourth directory for the year). Turnover rates for primary care providers ranged from 23 to 61 percent in St. Petersburg and from 17 to 25 percent in Cleveland. Turnover rates for cardiologists in St. Petersburg and Cleveland ranged from 13 to 54 percent and from 10 to 12 percent respectively.

Citing a previous study, Dallek and Dennington support the theory that MCO-provider disputes related to payment levels, risk-sharing arrangements, and payment delays resulted in substantial provider turnover in many Medicare+Choice markets. This, in addition to provider financial problems, have served as a sources of instability in the program as beneficiaries are forced to either change primary care providers or stay with their provider of choice and shift to another Medicare MCO or return to traditional Medicare fee-for-service. By examining individual MCO-provider relationships in Tucson, Tampa-St. Petersburg, and Tampa Bay, the researchers explain how contentious disagreements over contracts and reimbursement schedules between MCOs and large IPA and hospital-based networks ultimately resulted in terminated relationships. It appeared that sometimes these disagreements were initiated as negotiation tactics, as one insurance broker described the St. Petersburg health care marketplace as a war zone with providers and MCOs “putting a gun to each other’s head.”

Using a case study of a large provider group in Tucson, Dallek and Dennington walked through a chronology of financial problems that eventually lead to the closing of the group after

78 years in operation. The MCOs involved, had passed the financial risk downstream to the group using capitated agreements. Unable to control its increasing costs, the provider group was faced with serious financial problems that culminated in bankruptcy. As the researchers indicated, this scenario was played out in other cities in the study, frequently involving large IPAs and other physician organizations.

In summary, studies of the Medicare+Choice Program showed there were a number of factors that could influence an MCO's decision to stay or withdraw from the Program, including competitive disadvantages, base payment rates not indexed to inflation, and increased use and cost of health care services. Also cited by some researchers was the role the provider network played. Those authors explored the impact of contentious MCO-provider relationships, provider unwillingness to accept MCO payment levels and risk sharing arrangements, provider financial instability, and eventual provider withdrawals. The most common theme was financial related: payments by MCOs to providers were insufficient to ensure appropriate beneficiary access to health care providers. So the question was, would additional dollars help stabilize the provider networks and subsequently influence an MCO's decision to continue or not to continue participation in the Medicare program?

The Benefits Improvement and Protection Act (BIPA)

As 2000 came to an end, MCO withdrawals from the Medicare program continued to increase with the resulting decrease in beneficiary enrollment. In an effort to halt the bleeding of the Medicare+Choice program, Congress enacted the Benefits Improvement and Protection Act (BIPA) in December of that year, in response to pressure from the health insurance industry to roll back some of the provisions of the BBA (Achman and Gold, 2002). Hoping to stop the exodus from the program and encourage those MCOs that had announced their departure to

return, BIPA was designed to support the BBA mission to provide beneficiary choice and encourage migration of Medicare enrollment to the budget controlled environment of Medicare+Choice plans.

According to a review by the Congressional Research Service (1997), there is a correlation between the number of Medicare MCO plans available to a beneficiary and the likelihood of being enrolled in one. The report states that, “fewer than 10 percent of beneficiaries with two or fewer plans available have enrolled in a plan. At the same time, more than 30 percent of those beneficiaries in areas where nine or more risk contract plans are available are enrolled in one of those plans.” The objective of BIPA was to increase the number of plans participating in the program and thus increase beneficiary choice.

Provisions and Restrictions of BIPA

The BIPA provisions revised the BBA payment arrangements by increasing monthly payments to MCOs in one of three ways:

1. MCOs received a new minimum floor payment, thus raising the 2001 monthly floor payment rate per enrollee to \$475 (referred to as “floor plans” [*note: MCOs and HMOs are frequently referred to as “health plans” or “plans”*]);
2. MCOs received a newly established floor rate of \$525 if their contract areas were in urban counties with populations of 250,000 or more (also referred to as “floor plans”); and,
3. MCOs received an additional 1 percent, thus raising the 2 percent increase limit to 3 percent for the year 2001 (referred to as “non floor plans)

BIPA also offered bonus payments to MCOs entering a county where no other MCO had been offered since 1997 or where coverage was to be discontinued in 2001 (HCFA, 2001).

The largest rate increases went to floor plans in counties where floor payments were increased to \$525 (9.7% increase), and where floor payments were increased to \$475 (8.3% increase). These floor plans operate in areas that represent nearly one quarter of the Medicare+

Choice enrollment. The remaining 75+ percent of enrollees reside in counties in which the non-floor plans received only the 1 percent increase.

Congress placed restrictions on how the additional dollars could be spent. The MCOs could use the money to: 1) reduce beneficiary premiums or cost sharing (e.g., co-pays); 2) enhance benefits; 3) enhance the network of healthcare providers available to beneficiaries; and 4) reserve funds to help offset premium increases or benefit reductions in the future through contributions to a benefit stabilization fund.

How MCOs Used Their BIPA Funds

The majority of MCO plans elected to use their additional dollars to enhance their provider networks. According to CMS (HCFA 2001): 65 percent of enrollees were in MCOs that used funds to enhance provider networks only; 6 percent were in MCOs that used funds to reduce premiums or cost sharing only; 1 percent were in MCOs that used funds to add or enhance benefits only; and 11 percent were in MCOs that placed the additional dollars into reserve via the benefit stabilization fund. Seventeen percent of enrollees were in MCOs that elected to use their additional dollars for multiple options.

The non-floor plans used over 72% of their additional payments to enhance the provider network, compared to 48.6% of \$475 floor plans and 43.5% of \$525 floor plans. Of interest is the fact that MCOs in the counties that received the largest rate increases were less likely to use the additional dollars for provider network enhancement only. The floor plans were much more likely to use their funds for multiple options (42.1% for \$475 plans and 45% for \$525 plans) compared to non-floor plans (7.3%) (HCFA, 2001).

Impact of BIPA on MCO Participation

Of the 60 MCOs that had announced their withdrawal from the program in 2001, only four re-entered with a total of 13,000 beneficiaries enrolled. (The four MCOs included three that reentered counties they had dropped from their service areas and one that reentered previously served counties and expanded into new ones.) The four MCOs provided services in 11 counties in three states. In six of the 11 counties, the county payment rates were increased by over 20 percent. Of the four MCOs, one re-entered a market in five counties in one state for which there was no other Medicare+Choice MCO alternative and was therefore targeted for the bonus payment (HCFA, 2001). However, due to the late passage of BIPA, MCOs had to scramble to make changes to re-enter, so timing may have been a factor. CMS required that revised rate proposals and benefit packages be submitted within a two-week time period and MCOs had to quickly notify enrollees of the proposed changes (Gold and Achman, 2001).

An evaluation of BIPA concluded that the legislation failed to improve availability of MCOs for Medicare beneficiaries. In response to a congressional request, the United States General Accounting Office (GAO) prepared a report evaluating: 1) how MCOs used the additional funds authorized by BIPA in 2001; and, 2) the effect of BIPA on the availability of MCOs to increase choice for beneficiaries (GAO, November 2001). To conduct the study, the GAO analyzed Medicare program data maintained by CMS (such as number of MCOs under contract, number of beneficiaries enrolled, number of service areas, etc.) and interviewed agency officials responsible for implementing BIPA's payment provisions. The GAO also consulted with the seven MCOs that contracted to serve new areas following the passage of BIPA (the four MCOs previously mentioned that reentered the Medicare program and three MCOs that expanded into counties they previous had not served). As part of the evaluation, all the MCOs'

pre-BIPA (initial) and post-BIPA (revised) 2001 contract proposals were reviewed to assess the types and extent of changes MCOs indicated for costs and covered benefits.

The GAO report stated that most MCOs (83%) used some or all of the additional funds to enhance or stabilize their provider networks. Some of the MCOs reported that they increased payments to their providers or contracted with additional providers to improve beneficiaries' access to care. Findings of the GAO study also indicated the BIPA policy had little effect on the availability of MCOs during 2001. Following the implementation of BIPA, only three MCOs reentered counties they had exited, three expanded into counties they had not previously served, and one MCO both reentered and expanded territory. A total of 750,000 beneficiaries live in those counties and all but 21,000 already had access to at least one MCO in 2001. The MCOs that expanded into new counties reported that they would have done so without increased payments, as their expansions were part of planned strategic moves that had already been determined prior to BIPA passage.

Opportunities for Additional Study of the BIPA Policy

The evaluation conducted by the GAO began in July 2001, just four months after the BIPA funds began to flow to the MCOs. Because the study was conducted during the funding period, its scope was limited to assessing whether or not MCOs took advantage of the BIPA program. The evaluation simply quantified the MCOs that received BIPA dollars, the MCOs' expenditures of those dollars, the beneficiaries impacted, and the counties reentered. Although interviews were conducted with agency officials and MCO representatives for the purposes of qualitative analysis of the policy, it was simply too soon to do much beyond explore the effects of a rapid policy implementation.

With the passage of time, more data became available to analyze the long term impact of the policy. Building upon the earlier studies that cited financial problems between the MCOs and their provider networks, it was possible to study whether or not the infusion of additional dollars into the MCOs' coffers helped them stabilize these critical relationships. Although the GAO report found BIPA to be ineffective in increasing beneficiary choice in the number of MCOs, in the long run, was the policy effective in retaining those MCOs that took advantage of the financial opportunity to stabilize beneficiary access to providers?

CHAPTER 3

RESEARCH METHODOLOGY

Research Questions

This study attempted to answer three questions related to those MCOs that elected to dedicate all or a portion of their BIPA funds to the stabilization of their provider networks:

1. Did the use of BIPA funds to either exclusively or partially stabilize a provider network impact an MCO's decision to remain in the Medicare+Choice Program?
2. Did those MCOs that used the additional BIPA dollars either exclusively or partially to stabilize their provider networks in fact do so?
3. Does an unstable provider network impact an MCO's participation in the Medicare+Choice Program?

Research Design

The quasi-experimental methodology for this explanatory study used an ex-post facto control group design. Using secondary data available at the CMS research website, information on individual MCO plans could be compared. Because this study was conducted following the effective date of the BIPA legislation, there was no opportunity to control implementation of the program and; therefore, this study was an attempt to measure the effects of the additional dollars into the Medicare+Choice program after the fact.

All data for this study were provided by CMS staff or were available at the CMS "Medicare Managed Care and Medicare + Choice Reports, Files, and Data" web site. These data included contract information on all MCO plans participating in the Medicare + Choice Program, information on how the various MCOs elected to use their additional BIPA dollars, and annual

practitioner turnover rates for each participating MCO that was used as an indicator of network stability.

The population for this study was all MCOs that were affiliated with the Medicare + Choice Program during the 2001 contract year. In using the full census of this population, the individual MCOs were the units of analysis for this review and sample-to-population generalizability was not an issue.

Independent Variables

MCOs contract with CMS to provide health care coverage for Medicare beneficiaries in a specified service area. Each contract is tracked by CMS under a unique contract number. For purposes of this study, this contracted number was used as the unique identifier to link information across the study data sets.

However, an MCO may offer Medicare beneficiaries more than one set of benefits within its contracted area. For example an MCO may identify the entire state of Nevada as its contract area with CMS, but due to the availability of health care services, offer one benefit package in urban Las Vegas and another benefit package in rural Ely. These different benefit packages (or “plans”) are individually identified with CMS under a plan ID number.

The independent variables for this study, the BIPA funds, were allocated to the MCOs based on benefit package and therefore the data set provided by CMS for this study was supplied at the individual plan ID number level. The detail that was provided in the data set for each plan ID number included not only how the BIPA funds were initially allocated (such as “Added Benefit”) but how they were allocated at a secondary level (such as “Prescription Benefit”). For the purposes of this study, all of the possible allocation options had to be collapsed for each plan ID number into one of 3 categories:

- “Nothing allocated to the provider network”
- “Any portion allocated to the provider network”
- “Exclusively allocated to the provider network”

The BIPA fund allocation data then had to be further collapsed to the individual MCO contract number level to allow for linking with the other data set. This was done by identifying the most common plan ID number category of use. In cases of a tie, the MCO was identified for the second category (“Any portion”) to be conservative. Collapsing the BIPA fund allocation data was a potential study limitation, however it was assumed that the most frequently used category best reflected of how the BIPA dollars were spent by the MCO

Dependent Variables

Provider network stability is measured by the amount of movement of individual practitioners in and out of a provider network. In the study conducted by Dallek and Dennington (2002), in which they investigated physician withdrawals from Medicare+Choice MCOs as a source of program instability, they did so by analyzing MCO provider directories from one year and comparing them to the provider directories two years later. Although this methodology provided some sense of an MCO’s provider turnover rate, the data was subject to challenges of validity and reliability and the study design would be difficult to replicate on a larger scale. HEDIS offered a much more valid and reliable indicator.

HEDIS (Health Plan Employer Data and Information Set) is a set of standardized performance measures that is administered by the National Committee for Quality Assurance (NCQA) to assess the quality of health care and services provided by managed care plans.¹ The

¹ In 1996, as a public purchaser of health care, CMS adopted HEDIS as a methodology for assessing its contracted MCOs’ performance, mandating that all MCOs contracted with CMS submit a number of selected performance measures from HEDIS 3.0 (CMS, 1997). MCOs must submit HEDIS data for the previous calendar year to CMS by June of each year. Prior to submission to CMS, the MCOs’ HEDIS reports must be audited by independent HEDIS

HEDIS data set consists of eight “domains” containing over 50 quality indicators. Provider Turnover is one of the indicators in the Health Plan Stability domain and offers facial and content validity as a measure of network stability. It is also reliable, as the technical specifications for this measure did not change between reporting year 2000 (NCQA 2001) and reporting year 2002 (NCQA 2003) and all data was independently audited prior to submission to CMS. The measure is used by CMS each year to determine the percent of primary care providers who left an MCO’s network, regardless of reason for termination. The denominator for this measure is the number of primary care providers who were contracted with an MCO on December 31st of the year prior to the reporting year. The numerator is the number of those primary care providers in the denominator who were not contracted with the MCO on December 31st of the reporting year.

Because an MCO may cover more than one geographical region (e.g., northern, central, and southern California), it may report more than one provider turnover rate per contract number². To serve as a dependent variable for this study, multiple provider turnover rates had to be collapsed to the study’s common unique identifier, the MCO contract number. If an MCO contract number had more than one provider turnover rate reported, the rates were averaged to determine one annual provider turnover rate for each year of the study. Again, the need to collapse the data was a potential study limitation. However, it was assumed that in the absence of the raw data for the individual MCOs, the average rate provided the closest approximation of the MCOs network stability as a whole.

auditors to ensure the MCOs prepare the reports in full compliance with the HEDIS technical specifications. The auditors are certified by NCQA to ensure interrater reliability in the review of MCO HEDIS data.

² “The reporting unit for CMS is a “contract market.” CMS signs contracts with health plans to provide health care for a given geographic area. A contract market is usually the entire contract area. However, CMS did not believe that HEDIS results would adequately represent local health care when a contract covers a large geographic region with high enrollment. For this reason, CMS broke large contracts covering several areas with high enrollment into smaller “market areas” containing at least 5,000 beneficiaries.” (CMS, 2001)

The second dependent variable for this study was the MCO's status in the Medicare+Choice program. As an evaluation covering multiple years, this variable was measured using the MCOs decision to "Term by 2003" or "Stay through 2003." This decision was reflective of whether or not the organization appeared in the list of MCOs that filed HEDIS reports each year.

Analysis Assumptions

The above data sets were then combined into one file for statistical analysis using the MCO contract number as the unique identifier. In analyzing the data, the following assumptions were made:

- Those MCOs that submitted HEDIS data in 2001, but did not submit in 2002 or 2003, terminated their contract with CMS sometime in 2001.
- Those MCOs that submitted HEDIS data in 2001 and 2002, but did not submit in 2003, terminated their contracts with CMS sometime in 2002.
- Those MCOs that did not submit HEDIS data in 2001 were unable to do so because they did not meet the minimum reporting requirements³. These organizations were therefore excluded from the analysis of the first and last study questions, which address an MCO's decision to continue participation in the Medicare Program. In years 2002 and 2003, a few of these MCOs did subsequently submit data, which were included in the other analyses using average Provider Turnover Rate (PTR).

³ According to Chapter 5 of the MCS Medicare Managed Care Manual, the published regulations governing CMS's contracts with the MCOs (CMS, 2004), an organization is exempt from reporting HEDIS measures if it does not meet specified reporting requirements. These requirements include criteria such as: minimum enrollment of 1,000 members on July 1st of the measurement year; CMS contract in effect on January 1st of the measurement year; initial enrollment on January 1st of the measurement year; and reporting only by the surviving entity of a merger or acquisition. There are also MCOs with special circumstances that are exempt from HEDIS reporting, such as demonstration projects that contain specific waivers in their CMS contract.

- Two MCOs submitted data in 2001 and 2003; but not in 2002. It is assumed they were unable to submit data in 2002, however remained in the program for all three years.

CHAPTER 4

FINDINGS

The two data sets were combined using the CMS contract number as the unique identifier. A total of 176 MCOs received BIPA funds in calendar year 2001. It is assumed that as active participants in the Medicare+Choice Program in 2001, all 176 MCOs attempted to submit HEDIS reports in 2001 for data year 2000.

Table 1 below details the terminations and HEDIS submissions of the 176 MCOs that received BIPA funds in 2001 (“BIPA MCOs”):

Table 1. BIPA MCO Terminations and HEDIS Submissions			
	2001	2002	2003
Total of BIPA MCOs that received funds in 2001	176	176	176
Less: Terminated CMS contract in 2001		28	28
Less: Terminated CMS contract in 2002			5
Remaining BIPA MCOs in Medicare+Choice Program	176	148	143
Less: Assumed did not meet HEDIS minimum reporting requirements	22	20	13
BIPA MCOs that submitted annual HEDIS data	154	128	130
Less: Submitted HEDIS data, <u>excluding</u> the PTR* measure	11	7	5
Submitted HEDIS data, <u>including</u> the PTR* measure	143	121	125

* *Provider Turnover Rate*

Of the 176 organizations that received BIPA funds in 2001, 28 terminated their contracts with CMS during 2001 and 5 terminated their contracts in 2002. A total of 22, 20, and 13 MCOs did not submit HEDIS data to CMS in 2001, 2002, and 2003, respectively. Of the remaining 154 MCOs that did submit 2001 HEDIS data, 11 were unable to, or elected not to, report the Provider

Turnover measure⁴. In 2002 this number dropped to 7 and in 2003 to only 5 did not report this measure.

Impact of BIPA Funds on MCO Participation

Did the use of BIPA funds to either exclusively or partially enhance a provider network impact an MCO's decision to remain in the Medicare+Choice Program? MCOs that used their BIPA funds exclusively for network enhancement were compared to those MCOs that used a proportion of their funds for network enhancement and those that did not use their funds for network enhancement at all. The percent of MCOs that "Termed by 2003" and the percent that "Stayed through 2003" were calculated and compared for each group to determine the impact of each respective option.

Distribution of BIPA Funds	Termed by 2003		Stayed thru 2003		Total	
	#	%	#	%	#	%
Exclusive to Network	22	26.8%	60	73.2%	82	100%
Proportion to Network	8	16.0%	42	84.0%	50	100%
Nothing to Network	3	13.6%	19	86.4%	22	100%

Of the 82 MCOs that used their BIPA funds exclusively for the enhancement of their provider network, 26.8% terminated their contract with CMS before 2003 and 73.2% stayed through 2003. This is compared to the 50 MCOs that used a portion of their BIPA funds towards network stability, of which 16% terminated before 2003 and 84% stayed through 2003. Of the 22 MCOs that elected not to allocate any funds towards their provider network, 13.6% terminated their contract with CMS by 2003 and 86.4% stayed in the Medicare program through

⁴ MCOs report an NR (Not Report) when they choose not to calculate and report a rate (due to possible issues such as inability to capture the necessary data), or of the MCOs certified HEDIS compliance auditor determines that a rate is materially biased (CMS, 2001).

2003. Using Pearson Chi-Square significance testing, these results showed no relationship between the distribution of the BIPA funds and the MCO's contract status.

It is possible the MCOs that allocated all or a portion of the BIPA funds to their network and still termed by 2003 were in serious trouble before the implementation of the BIPA policy. They may have had other problems not related to their provider networks that ultimately played out in their decision not to renew their CMS contract. If their problems were provider network related, the funds may have simply arrived too late to remedy their problems, or were insufficient to address their issues. It is also possible that those MCOs that allocated nothing to the stability of their networks did so because they did not have problems with their providers, but instead were facing challenges in other areas that the BIPA funds did address, such as enhancement of benefits or reduction in premium costs.

Impact of BIPA Funds on MCO Provider Network Stability

One of the study objectives was to determine whether or not those MCOs that used the additional BIPA dollars either exclusively or partially to enhance beneficiary access to providers did in fact stabilize their provider network, i.e., reduce their provider turnover rate. Table 3 below shows the number of MCOs that distributed their BIPA funds exclusively, partially, or not at all for network enhancement and their respective average provider turnover rates for baseline year 2000 (prior to distribution of the funds), and the following two years.

Table 3. Impact of BIPA Funds on MCO Provider Network Stability						
Distribution of BIPA Funds	Turnover Rate 2000		Turnover Rate 2001		Turnover Rate 2002	
	N	Mean	N	Mean	N	Mean
Exclusive to Network	75	13.49	59	14.76	62	13.16
Proportion to Network	46	13.89	43	12.98	42	12.20
Nothing to Network	22	12.41	19	13.27	21	14.55

The provider turnover rate for those MCOs that allocated the funds exclusively to the network showed an average turnover rate increase from 13.49 in 2000 to 14.76 in 2001 and a subsequent decline to 13.16 percent in 2002. Those MCOs that allocated a portion of their funds to their provider network experienced an annual reduction in their average provider turnover rate from 13.89% in 2000, to 12.98% in 2001, to 12.20% in 2002. For those MCOs that did not allocate any dollars to the provider, the average provider turnover rate actually increased from 12.41% to 13.27% to 14.55% for 2000, 2001, and 2002 respectively. However when a one way ANOVA test was applied, no statistically significant differences were found across these three groups. (For comparison purposes, the national average provider turnover rates for all MCOs participating in the Medicare+Choice Program was 12.61%, 10.89%, and 12.1% for years 2000, 2001, and 2002 respectively (NCQA).)

It is possible that for those MCOs that used their funds for more than just stabilization of their network, doing so solved other problems that may have been impacting their provider networks. For example, if BIPA dollars were also used to provide beneficiaries coverage for more health care benefits, providers may have profited by having more of their services paid for by the MCO rather than by financially strapped beneficiaries. A scenario such as this could have encouraged the providers to stay with the MCO.

Provider Network Stability and MCO Participation

The final question for this study asks whether high provider turnover rate impacts an MCO's contract status with CMS. BIPA funds were supplied to the MCOs starting early 2001. Using the calendar year 2001 average Provider Turnover Rate, an analysis of those MCOs that maintained their contracts with CMS for the Medicare program through 2002 and those MCOs that retained their contract through 2003 is provided below.

Table 4. Impact of Provider Turnover Rate on MCO Participation in Medicare+Choice Program		
Status	Provider Turnover Rate for 2001*	
	N	Mean
Stayed through 2002	5	7.79
Stayed through 2003	114	14.16

* *A t-test was applied to the above results and the difference was found not to be significant; however statistical analysis is limited due to the small number of MCOs identified as “ Stayed through 2002.”*

It is interesting to note that for those MCOs that stayed through 2002, the average provider turnover rate was 7.79, as compared to the MCOs that elected to continue their participation in the program through 2003 with an average provider turnover rate that is almost double at 14.16. But when a t-test was applied, this difference was not significant; however as only five MCOs terminated at the end of 2002, it was difficult to do statistical comparison on such a small number.

Speculations that could be drawn that these data are telling another story. For one, provider turnover is not always a negative experience for an MCO. Sometimes an organization may need to clean house of disgruntled providers who are costing them with contentious dealings over claim payments, or higher payment rates than the MCO can afford, or even bad mouthing of the MCO to its beneficiaries. By eliminating these unhappy providers from its network, an MCO may in fact be freed up to contract with new supportive providers who then enable it to continue its Medicare+Choice contract. It is also possible that a number of providers could chose to eliminate themselves from a successful MCOs network for a variety of reasons, such as frustration with the MCO’s rules for payment of services or the payment rates themselves. This would be reflected in a higher turnover rate for the MCO, but it may not greatly impact a strong MCO that could easily negotiate new contracts.

Study Limitations

The technical specifications for preparing the HEDIS Practitioner Turnover measure requires that MCOs include only primary care providers (PCPs) in the measure. Turnover for specialists (such as cardiologists, neurologists, endocrinologists, etc.) is not tracked or reported. However, in the managed care gatekeeper model, the PCP is the initial point of contact for care, provides the vast majority of the patient's care, and is responsible for making referrals to specialists as necessary. Therefore, the measure is still a strong indicator of network stability, as PCPs form the framework of an MCO's network.

The Practitioner Turnover rate also has limitations similar to those of the Dallek and Dennington cited earlier in that it is a snapshot in time. Measuring which providers are in a network from December 31st of the previous year to December 31st of the reporting year does not reflect the dramatic movement in and out of the network that can take place during a 12-month period.

Another limitation of this study is the fact that the additional funds started to flow to MCOs on March 1, 2001. There were two months during the reporting year 2001 in which the independent variable was not implemented. The technical specifications for the HEDIS Practitioner Turnover measure does not allow for evaluation of changes in a network on a monthly basis. There may be factors that occurred during January and February of 2001 that would influence a practitioner's decision to leave an MCO's network, however given the parameters of the measure, it is not possible to statistically control for them.

CHAPTER 5

CONCLUSIONS

According to the report produced by the GAO (GAO, November 2001), the \$1 billion dollars that were infused into the program via the BIPA legislation had little effect on improving overall availability of MCOs for Medicare beneficiaries during 2001.

Because the vast majority of organizations elected to funnel their additional BIPA funds into efforts to stabilize or enhance beneficiary access to providers, the purpose of this paper was to explore the possible relationships those decisions may have created among use of funds, provider network stability, and participation in the M+C Program. The findings of this study show there were no statistically significant relationships among any of the above variables. It appears that despite the decision of most MCOs to flow dollars into their provider network, they were not successful in stabilizing or enhancing them, and participation in the Program continued to decline.

However other factors may have been at play during this time period. Struggles with provider networks were not the only challenges MCOs faced. Organizations were also faced with implementing and complying with burdensome regulations that were imposed as part of the Balanced Budget Act. Some of these regulatory burdens were so onerous they appear to have played a role in keeping other organizations such preferred provider organizations, religious fraternal benefits plans, and provider sponsored organizations from even participating in the Medicare+Choice program. For the MCOs, they may have decided their ongoing operational costs were too great to justify continuation in the program.

This was also a period of new business opportunities for many MCOs in the non-government commercial market. Large commercial purchasers were looking for innovative

ways to save money on the health insurance coverage they offered their employees. Many MCOs decided to devote the resources to designing and building this more lucrative, less regulated portfolio of business, and elected to walk away from the Medicare+Choice program.

For some MCOs the Medicare business may have represented such a small portion of their overall business, there may not have been enough profit, or perhaps any profit, to make worthwhile to continue a contract with CMS. Frequently medium and large MCO have multiple lines of business, including various types of commercial as well as other governmental business, such as Medicaid or the Federal Employees program. Unless each line of business can pay for itself and turn a profit, an MCO may elect to drop it from its portfolio. This could have been the case for some of the MCOs that chose to withdraw from the Medicare+Choice program.

It is also important to note the impact of the late passage of the BIPA legislation, which may have played a critical role in what appears to be the policy's failure. The GAO report (2001), included comments from the agency, CMS, agreeing with the general observation that the Act may not have provided MCOs "sufficient time to react to the legislation and reconsider and reverse carefully considered financial decision, or to rebuild provider networks." To launch the policy, the law required participating MCOs to submit revised contract proposals for that portion of the 2001 contract year that would be affected (March through December). Normally the process of contract proposal and review takes six months, however due to the short deadline to start distributing the additional funds, this process was compressed into six weeks. This meant MCOs had two weeks to consider their options for using the additional dollars and make sound decisions regarding participation in the Medicare program, instead of the usual four months. The two-week due date for proposals caused MCOs to scramble, not only to submit proposed benefit packets for review by CMS, but also to make organizational changes to re-enter markets they had

decided to exit. Other researchers have cited this implementation timetable as a possible barrier to making BIPA effective in bringing more MCOs back into the Medicare program (Gold and Achman, 2001). The MCOs simply may not have had sufficient time to evaluate their financial options.

Despite its failings, the BIPA experience does offer other evaluation alternatives. There were three MCOs that reentered counties they had dropped from their service areas and three MCOs expanded into counties they previously had not served. Interesting studies could be conducted on beneficiary behavior in counties that added additional MCOs and on reasons that MCOs continued to participate in the Medicare+Choice program. Although MCOs may have expanded into service areas in which another MCO was already present, did the additional MCOs spur more beneficiary enrollment in the Medicare+Choice? Did the simple availability of more MCO's in those areas increase beneficiary awareness of alternatives to traditional fee-for-service health care? And why do MCOs elect to continue in the Medicare+Choice program? Did the MCOs that remained in the program during years 2000 to 2003 do so because of the additional payments? If not, what other forces influenced their business decisions to maintain their contracts? Studies such as these may provide insight into beneficiary behavior and MCO decision-making that could open the door for other Medicare-related policies.

The M+C Program's survival is dependent upon a payment system that appropriately reimburses MCOs for the financial risks they assume while allowing for the cost savings envisioned by the architects of the Balanced Budget Act of 1997 (BBA). The BIPA legislation was just one component in Congress' effort to meet these goals. With the enactment of the BBA, Congress initiated a new payment structure that is being phased-in over a number of years using risk adjustments that pay MCOs more for treating sicker, and therefore more costly,

beneficiaries (HCFA, 2001). The Medicare Payment Advisory Commission (MedPAC), an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program, issued a report supporting the additional BBA modifications made in the Balanced Budget Refinement Act (BBRA) (MedPac, 2000). Specifically, MedPac cited the change in deadline for MCOs to submit their annual application for participation in the M+C Program from May 1 to July 1, allowing MCOs more time to better forecast their program costs for the following year and thus have more confidence in the cost and benefit applications they submit. Also cited was the provision to allow MCOs to segment their service areas along county lines and charge higher premiums to beneficiaries living in areas with lower payments; this would allow MCOs to better match their revenues to costs and thus continue in the Program rather than withdraw. Passage of The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) created the new Medicare Advantage Program with a bidding process in which each MCO will have to submit a bid on an annual basis that identifies the level of government payment it actually needs to offer its benefit package (CMS, 2004). As with disbursements provided under the Medicare+Choice Program, these bids will be risk adjusted to compensate for beneficiary health status. To promote beneficiary choice, the MMA will provide for the establishment of Regional Medicare Advantage health plans that will compete along side the current local level MCOs. CMS believes the MMA-initiated changes will increase not only the number and stability of health plans participating in Medicare, but also increase the types of health plans.

GLOSSARY OF TERMS

AAPCC: Adjusted Average Per Capita Cost (payment methodology used in the Medicare Program, whereby insurance plans are paid a county specific rate by the federal government to provide health care services to Medicare beneficiaries enrolled in their insurance plan).

BIPA: Benefits Improvement and Protection Act of 2000.

BBA: Balanced Budget Act of 1997.

Capitation: Cost risk sharing system of payment commonly used in the health care industry by Managed Care Organizations, by which contracted health care providers are paid a fixed rate per month for each patient served rather than by service performed.

CMS: Centers for Medicare and Medicaid Services (federal government agency responsible for administration of the Medicare and Medicaid programs).

Fee-for-Service: System of payment used in the health care industry whereby health care providers are paid for each service performed.

Floor Plan: MCOs that received the minimum dollar amount (“floor”) established by the Balanced Budget Act of 1997.

HCFA: Health Care Finance Administration (previous name for the Centers for Medicare and Medicaid Services).

HEDIS: Health Plan Employer Data and Information Set (a set of standardized performance measures that is administered by the National Committee for Quality Assurance to assess the quality of health care and services provided by managed care organizations).

HMO: Health Maintenance Organization.

IPA: Independent Practice Association

MCO: Managed Care Organization, such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO).

Medicare + Choice Program: Medicare program established by the Balanced Budget Act of 1997 to give Medicare beneficiaries an option of enrolling in a variety of private health plans, including HMOs.

TEFRA: Tax Equity and Fiscal Responsibility Act.

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